



Member Information

Last Name: _____ First Name: _____ M.I.: _____

Male Female

Social Security Number: _____ - _____ - _____

Single Married

Date of Birth: ____ / ____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Email: _____

Plan Information

Diagnostic Advantage (Diagnostic Direct, DVP Essentials & Wellness Select):

- Individual - \$42 per month
- Family - \$55 per month

Diagnostic Plus (Diagnostic Direct & DVP Essentials):

- Individual - \$34 per month
- Family - \$45 per month

Diagnostic Direct only:

- Individual - \$20 per month
- Family - \$25 per month

DVP Essentials only:

- Individual - \$14 per month
- Family - \$20 per month

Wellness Select only:

- Individual - \$8 per month
- Family - \$10 per month

Total Monthly Dues: \$ _____

Family Information

Last Name	First Name	Birth Date	Sex	Spouse or Dependent?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Payment Information

I would like to pay for my program (select one): Monthly Semi-Annually Annually

Form of Payment (select one):

Bank Draft

Name of Bank: _____
Account Number: _____
ABA Routing Number: _____

I hereby request and authorize the aforementioned bank (Depository Bank) to pay drafts in such amounts as may now or hereafter be payable to LifePerks Benefits Network, LTD. Provided there are sufficient funds in said account to pay the same upon request. This authority shall remain in full force and effect until LifePerks Benefits Network and/or Depository (bank) have received written notification from me of its termination in such a manner and time as to afford LifePerks Benefits Network or Depository (bank) a reasonable opportunity to act on it. I agree to notify LifePerks Benefits Network of any changes to my savings/checking account number or bank. I agree that LifePerks Benefits Network shall have no liability whatsoever except to the extent created by my payment.

X _____ Date: _____
Signature of Proposed Member

(please fax or mail a blank voided check with application for processing)

Credit Card

Select one: Visa Mastercard Discover American Express
Account Number: _____
Expiration Date (MM/YYYY): ____ / ____
Name on Card: _____
Billing Address: _____

I hereby authorize charging my credit card/bankcard.

X _____ Date: _____
Signature of Proposed Member

Member's Acknowledgement

The LifePerks for Health discount program is not an insurance policy. Rather, it is a discount program whereby the sponsors of the program have negotiated to obtain discounts from the providers of the services and goods. LifePerks Benefits Network through its agent or agents has negotiated these discounts with the providers to acquire the best possible discount for its Members, much the same way large companies do for their employees.

No portion of any provider's fee or cost will be reimbursed or otherwise paid by LifePerks Benefits Network. The Benefit Participant is solely responsible for payment of all provider fees and costs. LifePerks Benefits Network's only obligation under this agreement is to administer enrollment of the Benefit Participant and participating providers. LifePerks for Health discounts cannot be utilized in conjunction with any other discount program.

X _____ Date: _____
Signature of Proposed Member